Health

California's Health

Vol. 12, No. 15 · Published twice monthly · February 1, 1955

MEDICAL CONSULTATION IN THE STATE DEPARTMENT OF SOCIAL WELFARE

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Historically in California, public welfare agencies have looked to county hospitals and county health departments for help in medical and health matters. Help from the former has been limited to clinic and hospital care for indigent persons and those medically indigent. Health departments, too, have generally assisted in individual medical questions rather than in administration.

The State Department of Social Welfare has for many years employed a part-time medical consultant in the program for the blind. On other kinds of specific medical administrative problems, consultation has frequently been sought from the State Department of Public Health, whose several bureaus have responded to requests regarding problems of licensing hospitals, institutions and boarding homes; adoptions; day care centers; proposed legislation; aging; interpretations of medical materials, and preparation of manuals with health implications.

In 1953 the Department of Social Welfare inaugurated a special study of fathers whose families were receiving benefits under the Aid to Needy Children (ANC) program because of the father's incapacity. The aim of the special study was to determine the accuracy and adequacy of medical reporting in the ANC program, to evaluate methods utilizing such medical information, and to consider possibilities for correcting weaknesses in existing practices. The study was carried out jointly by the Departments of Social Welfare and Public Health during the latter part of 1953 and the first quarter of 1954, utilizing personnel from both departments. The report was submitted to the State Legislature in March of 1954.

In July, 1954, the California State Departments of Public Health and Social Welfare entered into a new and closer relationship through the services of a medical consultant (the author). He is assigned by Public Health to Social Welfare on the basis of a contract between the two departments to assist in the medical aspects of the Aid to Needy Children program.

RESULTS OF THE MEDICAL STUDY OF "INCAPACITATED FATHERS"

Many important findings resulted from the study. On the basis of the existing definition of incapacity, the validity of the county's determination that the father was incapacitated seemed doubtful in 12 percent of the cases. In only 47 percent of the cases could incapacity to work be definitely established upon medical review of the information found in the case records.

Pulmonary tuberculosis and diseases of the heart each accounted for about 15 percent of the incapacitated cases. A considerable portion of these and other cases reflected highly complex social and medical problems that could be prevented or ameliorated. Most of the case records contained insufficient medical information for a thorough evaluation of the individual and his problem.

The medical report forms currently in use are oriented primarily toward employability; hence the physician's statement usually does not reveal the findings needed either for a properly planned rehabilitation program or for case evaluation. Although 34 percent of the incapacitated father cases were referred by welfare departments to the Bureau of Vocational Rehabilitation, relatively few were acceptable by the latter's standards. In 40 percent of the cases not referred, some form of retraining seemed to be indicated.

Not more than a half-dozen county welfare departments have a systematic program of medical consultation, yet all are involved in large medical care expenditures on behalf of their clients, either directly or indirectly. The case workers have felt handicapped in attempting to perform a constructive job without proper consultation from other professional personnel such as physicians, medical social workers, rehabilitation counselors, public health personnel, employment experts and psychologists.

It was observed that the availability, and appropriate use, of health services often influence the ultimate amount of assistance granted. The thoroughness of diagnostic study, the type of treatment, the amount of effort put into rehabilitation and the efficiency in coordinating local resources usually determine the degree of success or failure in these cases.

Much of the difficulty in determining medical eligibility for ANC appeared to arise from the present administrative definition of incapacity and from the related regulations: e.g., a social worker is permitted to determine incapacity from his "observation of the client." Also, it was apparently difficult to secure a thorough, expert and prompt medical "work-up," including a medical report, from some of the public medical facilities.

Diagnostic studies performed on applicants for assistance frequently seemed to be too hurried and inadequate to serve as the basis for a realistic health appraisal. A comprehensive evaluation often was neglected. Often, too, treatment was unduly delayed, with irreparable harm to the client and ultimately greater cost to the program. Many health needs of the clients were overlooked because of unskilled case workers, heavy case loads, lack of health resources in the community, or poor communication between community agencies.

The Department of Social Welfare, until now having no medical consultation for the ANC program, found it difficult to work with the medical and allied professions, or to assist county welfare agencies with their health problems. One recommendation of the study of incapacitated fathers was that opportunities for improving health services to clients, especially in regard to preventive and rehabilitation measures in public welfare work, be developed through medical consultation.

ORGANIZATION OF THE DEPARTMENT OF SOCIAL WELFARE

In order to understand more fully the health and medical problems faced by the Department of Social Welfare, it may be helpful to examine its organization and functions.

The department has legal responsibility for the supervision of county welfare agencies, particularly for strict accounting of both federal and state funds in the categorical aid programs. Unlike the public health field, the state public welfare agency regularly reviews individual case records in local welfare departments. Supervisory function is further exercised through the development of policy, implemented by manuals, direct interpretation, and field services. Policies adopted by the Board of Social Welfare are developed in accordance with the Welfare and Institutions Code. In this type of state-county relationship, expert consultation is offered, but at the same time strict accountability is required.

The Department of Social Welfare tries to achieve consistency between established policy and its application in the counties. The degree of conformity must constantly be determined through field review of cases in every county. Field services are provided through area offices (located in Los Angeles, San Francisco and Sacramento), which serve as extensions of the headquarters office. There is a great deal of flexibility in the methods of operation designed to suit special conditions and county needs in their areas.

REORGANIZATION OF FIELD STAFF

In order to offer more effective service to counties, the Department of Social Welfare recently reorganized the work of its area offices, to involve them more directly in developing both policy and procedures, and to improve communication between the department and county agencies.

Reorganization took into account the need for two types of state representatives to work with counties. The first is the district representative. He acts as the department's contact person with county welfare directors, boards of supervisors, health agencies and other community organizations that are concerned with the policies or activities of county welfare departments. This representative is responsible for over-all program rather than for specific program content.

The second type of field worker is the program specialist, who is thoroughly familiar with a particular specialty and helps the local agency in that specialty. For example, a program specialist on rehabilitation would be an expert in this field, helping counties to improve services in this aspect of their work. The program specialist in medical consultation is engaged in preventive and rehabilitative services. This type of individual, found in each area office, is concerned with medical care, physical rehabilitation, employment and vocational counseling.

The significance to public health of area reorganization in the Aid to Needy Children program is that it should lead to greater coordination of county welfare activities with public health departments and other health agencies in the community. In addition, according to present contractual arrangements, the medical consultant to the State Department of Social Welfare will be working with the reorganized field staff. The field staff, in turn, will encourage welfare agencies to utilize the local health and medical professions in solving their multitudinous health problems.

AIMS OF MEDICAL CONSULTATION

What is the role of the medical consultant in this situation? The aim is to secure the best possible health care for recipients of assistance and to fully utilize this care in assisting clients and their families toward rehabilitation or the best possible adjustment to family and community life. Medical consultation seeks to accomplish this aim through:

1. Efficiency in the evaluation, treatment and rehabilitation of incapacitated clients receiving ANC.
2. Continuing guidance on medical aspects of policy, procedure, and legislation.
3. More effective relationships between local health and welfare agencies.
4. Better utilization of all local resources for guidance in medical and health problems.

It is planned that medical consultation will aid in policy formulation and in the development of procedures. For example, the current ANC Manual states, "the county shall determine * * * that the father is incapacitated by a physical or mental illness, defect or disability which prevents him from working full-time at regular employment."

Does "incapacitated" mean partial or complete? Who is to determine the degree of incapacity? What is "regular employment"?

In order to substantiate incapacity, the department requires only one of a variety of proofs, including "the worker's observation of a visible impairment." Is it proper to accept the observation of a case worker as proof of incapacity to work?

Other examples could be cited from the ANC Manual indicating the need for revision from the medical viewpoint, as sought by the State Department of Social Welfare. The fact that this manual is utilized not only by the state field staff, but also by county welfare departments, emphasizes the importance of an up-to-date, meaningful, clear-cut set of definitions.

An appropriate medical report form for use by welfare agencies seems indispensable to medical evaluation. At the present time, there is none recommended by the Department of Social Welfare. In current practice, examining physicians are asked principally for a diagnosis, an estimate of the duration of disability and a statement as to employability of the client.

Physicians are understandably reluctant to state who is "employable." Without more complete medical information on each case, the case worker cannot understand the medical implications of each case. Inasmuch as case records in county welfare agencies lack essential medical information, it is not surprising that some cases remain incapacitated or dependent for longer than would ordinarily be expected.

Case workers frequently are drawn into the midst of clients' health problems. Discussions and observations in the home may revolve about illness, physical and emotional complaints, family strife, questions of medical service, food, sanitation and other significant health matters. In this respect, the home visit is akin to that of the public health nurse. However, most welfare case workers usually have had no training in public health. Consequently, there is a real need for a health and medical guide. This should provide basic information of value to administrators and to social workers. This information would include medical administration techniques, the use of community resources, and emotional aspects of illness. It should aid county welfare departments to use more effectively the health, medical, rehabilitation and preventive services available. Further, it should help workers to comprehend what illness means to a client.

Medical liaison cannot be limited to public health and social welfare. Rather, it has been necessary to develop relationships on the state level with the Department of Education's Bureau of Vocational Rehabilitation, the Departments of Mental Hygiene and of Employment, and the California Conference of Local Health Officers; relationships have been developed on the regional level with the Regional Office of Public Assistance of the U. S. Department of Health, Education and Welfare, and on the local level with the field staff in each area office of the Department of Social Welfare, county welfare agencies, county hospitals, and practising physicians and dentists. All are playing some role in reducing dependency and ill health among public welfare clients with whom we are concerned. The challenge is to achieve effective coordination of services and a deeper understanding of the total needs of families in trouble.

COMMON BONDS BETWEEN HEALTH AND WELFARE

Perhaps the heart of the problem lies in the potential relationships between welfare and health agencies in the counties. Although common ground and close ties exist naturally between public health and public welfare, it may be helpful to look more closely at some of these since there is a trend developing in this direction which is beyond the scope of the present arrangement for consultation:

Health officers and welfare directors, public health nurses and social workers have a vital concern with tuberculosis, cancer, heart disease, post-polio and other health problems. Further, there is rapidly increasing interest in programs for the prevention of blindness, for home safety and for rehabilitation. Health departments are adding social workers and are associating more closely with county hospitals; welfare departments aim at better services for children, the health of mothers and incapacitated fathers. Opportunities for joint action abound in these fields as well as in sanitation, nutrition, health education and prevention of disease.

Administratively, agreements between public health and welfare departments may create channels for improved staff relationships, and thus more efficient service. Often there exists a need for medical consultation in a welfare department that the county health department is in the most strategic position to offer. Opportunities for joint in-service training should be capitalized. This may lead to cooperative work on selected cases, with real value. Eligibility determinations, too, are drawing health and welfare agencies together around problems connected with Crippled Children Services, tuberculosis and county hospital administration. Joint participation on special committees is growing, including such work as screening cases for rehabilitation referrals, securing jobs for the handicapped, evaluation of need for local mental hygiene clinics, promoting rehabilitation centers and other chronic disease facilities.

SUMMARY

In summary, it appears that the growth of specialized agencies has resulted to some extent in blinding us to the full potentialities of these specialties. Coordination is indispensable if we are to provide health and welfare services which will benefit, to the maximum, those who are temporarily dependent. Medical consultation to public welfare is intended to accelerate this coordination.

Influenza "Listening Posts" Manned in California

Again this year the State Department of Public Health has set up an influenza surveillance program in which "listening posts" have been manned throughout California to report the incidence and movement of influenza. The program, in which local health departments play a key role in collecting data from schools, hospitals, physicians, industry and other sources, is part of the national intelligence program and of the World Health Organization reporting system.

So far this year no outbreaks of influenza have been reported in California and no cases have been confirmed from more than 250 specimens sent to the Department's Viral and Rickettsial Laboratory.

In the first three weeks of January only nine specific requests for influ-

enza tests were made of the state laboratory and from current sources of information it seems evident that influenza, at this time, is not prevalent in the State. Higher than normal absenteeism reported from some areas is apparently due to other types of respiratory illness, types which are often confused with influenza.

Information in California is collected from four main sources: (1) reported cases of influenza, (2) reported deaths from influenza and pneumonia from eight selected cities, (3) reports from the incidence of respiratory disease in schools and industries from 10 "listening posts" areas throughout the State, and (4) laboratory reports of positive identification of cases of influenza.

The 10 health departments serving as "listening posts" are San Diego City and County, Los Angeles City, Los Angeles County, Santa Barbara City, San Joaquin County, Contra Costa County, Alameda County, San Francisco City and County, Marin County, and Humboldt-Del Norte Bi-County.

The surveillance stations report to the State Department of Public Health the occurrence of any unusual incidence of acute respiratory disease, estimate the number of persons involved, indicating what age or occupation groups are struck, and collect specimens for laboratory confirmation.

The information gathered weekly in this way keeps the State and local health departments aware of trends in acute respiratory diseases and of the presence and type of influenza virus.

Communications from the national intelligence network are summarized weekly in the Communicable Disease Summary of the National Office of Vital Statistics, Public Health Service, and are also distributed to health officials and interested research workers in the United States and other countries, and to the headquarters of WHO in Geneva. The program, operating on a world-wide basis, also facilitates the exchange of newly isolated strains of influenza virus for study purposes. The Department's Viral and Rickettsial Laboratory serves as a regional laboratory for WHO to ascertain when influenza is occurring and what type of virus is involved.

State Health Department Arranges For New Diagnostic Test for Syphilis

The California State Department of Public Health has arranged with the U. S. Public Health Service to make available to California physicians a new diagnostic test for syphilis. This test, known as the Treponema Pallidum Immobilization Test, is not intended as a routine diagnostic procedure. Its value lies in its greater accuracy and specificity when applied to doubtful cases. At present this test is offered by only 11 laboratories in the United States because it is a complex and difficult technical procedure.

Physicians who wish this diagnostic test for their patients should direct their request to the California State Department of Public Health, which has responsibility for reviewing technical data which will be requested with each specimen. Blood specimens will be processed at the Department's laboratory and shipped to the Venereal Disease Research Laboratory of the Public Health Service in Georgia, where the tests will be run. This service is being offered for a trial period, and on July 1, 1955, a decision will be made as to its continuation.

For the past three years the TPI test has been available on a limited basis to California physicians in connection with research being conducted at the UCLA Medical School under the direction of Dr. Charles M. Carpenter. The new program will supplement the UCLA service and make the test available on a wider basis.

The TPI test, developed by Dr. Robert A. Nelson at Johns Hopkins University in 1949, is a specific diagnostic test for syphilis. In addition to syphilis, the test gives a positive reaction only for yaws, pinta and bejel, but since those diseases do not occur in the United States, they are not of practical concern.

The usual standard blood tests for syphilis sometimes give positive reactions in persons who do not have syphilis. This poses one of the most perplexing problems that the physician may be called upon to decide in cases where patients have no other evidence of the disease. For some persons who are false positive reactors to standard blood tests, a decision to give treatment as a precautionary measure results in unnecessary treatment. Treatment labels them as syphilitic, frequently with considerable psychologic, sociologic and economic trauma. On the other hand, if treatment is withheld on the assumption that the patient is a false positive reactor, tragedy may result when some of these individuals subsequently develop disabling late manifestations, such as syphilis of the central nervous system, or of the heart and blood vessels. The TPI test is indicated in the diagnosis of such cases.

Special Census Releases

Series P-25. Estimates of the Population of Continental United States, by Region, Divisions, and States and of Alaska, Hawaii, Puerto Rico, the Canal Zone and the Virgin Islands, July 1, 1950 to 1953 (97); Estimates of the Population of the United States and the Components of Change by Age, Color and Sex, 1940 to 1950 (98); Provisional Estimates of the Population of the United States, January 1, 1950, to July 1, 1954 (99); Estimates of the Civilian Population of Voting Age for States, November, 1954 (100); Estimates of Population of the United States, by Age, Color, and Sex, July 1, 1954 (101); Provisional Estimates of the Population of the United States, January 1, 1950, to August 1, 1954 (102); Provisional Estimates of the Population of the United States, January 1, 1950, to September 1, 1954 (103); Provisional Estimates of the Civilian Population of Continental United States, by Regions, Divisions, and States and of Alaska, Hawaii, Puerto Rico, the Canal Zone, and the Virgin Islands, July 1, 1954 (104); Provisional Estimates of the Population of the United States, January 1, 1950, to October 1, 1954 (105).

Series P-27. Estimates of the Farm Population of the United States, April, 1950, to April, 1954 (20).

Bureau of Acute Communicable Diseases to Administer Venereal Disease Program

Administrative responsibility for the venereal disease program of the State Department of Public Health has been placed in the Bureau of Acute Communicable Diseases. While this abolishes the Bureau of Venereal Diseases, the importance of continued venereal disease control activities is not being de-emphasized.

Transfer of venereal disease control to the Bureau of Acute Communicable Diseases was made by the Director after due consideration of a recommendation of the Management Analysis Section, Department of Finance, which conducted a detailed study of the program at the request of the State Department of Public Health. Integration was recommended on the basis that both bureaus are concerned with control of communicable diseases, and that similar techniques are employed by each in their relations with local health departments and in carrying out their epidemiological investigations.

The Department of Finance in recommending the change made it clear that "transfer of * * * functions * * * does not imply a belief that the problem of venereal disease in California has been completely eliminated. * * * factors which cause the spread of the disease still exist."

Restricted Use of Public Water Reservoirs for Recreation Urged

Although aware of the important role adequate recreational facilities play in the promotion of health, the State Board of Public Health has urged the Legislature not to relax current laws restricting the use of public water supply reservoirs for recreation.

The board pointed out that the present provisions of the Health and Safety Code allow limited recreational use, including fishing, where it can be done without jeopardy to public health.

In a resolution passed at its January meeting in Los Angeles, the board said, "The State Board of Public Health recognizes its responsibility for promoting the total health of the people of California and is cognizant of the beneficial role of adequate recreational facilities in the promotion of health.

"The board recognizes that in certain situations recreational use of public water supplies under proper restrictions is feasible. The board, however, believes that present provisions of the Health and Safety Code afford needed protection to public water supplies while allowing restricted recreational use of water supply reservoirs when desired by local water purveyors and where it can be safely done.

"Therefore, the board desires to go on record as opposed to any enactment by the California State Legislature that would change the law so as to require public water supply reservoirs, whether publicly or privately owned, to be open to fishing or other recreational uses. Such requirement is, in its opinion, contrary to the best interests of the citizens of the State of California, in that it would constitute a potential danger to the public health, degrade the quality of water served to the public and increase the cost of water to the consumer."

California Births in 1954 Highest On Record; Exceed Deaths 3 to 1

In 1954 live births in California reached 299,000, according to preliminary estimates of the Department's Bureau of Records and Statistics. This is the highest year on record and compares with 296,944 live births in 1953 and 244,457 in 1950.

Births exceeded deaths by a ratio of nearly three to one, which has been the pattern in California for the last few years.

The 1954 deaths are estimated at 11,000, slightly higher than 1953. Further analysis of the data must be made to determine the leading causes of death, but they are not expected to change must from previous years in which diseases of the heart ranked first, followed by cancer and accidents.

Migration of people into California and natural increase (difference of births over deaths) share about equally as factors in population growth. Total population gain from July 1, 1953, to July 1, 1954, was 375,000—from an estimated 12,075,000 to 12,450,000. Of this total gain, 189,000 was due to natural increase, and the rest was attributed to migration.

It appears from provisional statistics that marriages in 1954 may drop below the figure for 1953. There were an estimated 78,000 marriages in 1954, as compared with 79,662 in 1953. An estimate for divorces and annulments is not yet available, since this information is not compiled on a current basis by the department, but is obtained from county clerks.

Public Health Positions

Los Angeles City

Assistant Director, Public Health Laboratories: Salary range, $575 to $715. Final filing date, March 15. Requires Ph.D. or Sc.D. in bacteriology or biochemistry, M.D., or D.V.M. degree from a recognized college or university and five years of professional experience in a medical or public health laboratory, three years of which included responsible supervisory or administrative duties, or an equivalent combination of training and experience. A valid California Public Health Bacteriologist Certificate or a valid license to practice medicine or veterinary medicine in California is required prior to certification.

Biostatistician: Salary range, $355 to $440. Applicants should be submitted as soon as possible. College graduation with courses in statistics is required, but experience in compiling and analyzing public health statistics may be substituted for the required education. Further information on the Los Angeles City positions may be obtained by writing the Board of Civil Service Commissioners, 5 City Hall, Los Angeles 12.

City of Ontario

Public Health Nurse: Salary range, $350-$430. Vacancy is for generalized school-city program. Write Bertha Schwarzwaelder, Chief Public Health Nurse, City Hall, Ontario.

San Bernardino County

The following openings exist in the San Bernardino County Health Department. All require certification or eligibility for certification with the State of California in their respective fields. For further information write the San Bernardino County Civil Service Office, 236 Third Street, San Bernardino.

Bacteriologist (Laboratory Technician II)	
Salary range	$311-$378
Sanitarians	
Barstow and desert district	$397
San Bernardino Valley	$327-$397
Supervising Public Health Nurse	$360-$438
Public Health Nurses	
Barstow	$360-$397
San Bernardino Valley	$327-$397

WHAT DO THE FIGURES MEAN?

In the December issue of *California Safety News*, official publication of the Department of Industrial Relations, Division of Industrial Safety, M. I. Gershenson, Chief of the Department's Division of Labor Statistics and Research, presents an interesting account of work injuries to Californians. His article is reprinted here by permission of the editors of *California Safety News*.

Half a million California workers are injured at work each year, according to a five-year average.

Of this number, more than 140,000 are disabled—that is, unable to report for work the day after they are injured.

And more than 750 of them die from their injuries.

What do these figures mean?

The Figures Mean This

One California worker is injured every 14 seconds.

One California worker is disabled every minute.

Three California workers die every day from work injuries.

(The figures are based on a 40-hour work week.)

The Disabling Injuries Picture

If we took only those who are disabled—(just one-fourth of all who are injured)—and placed each one in a separate ambulance, **the line of ambulances, bumper to bumper, would stretch all the way from San Francisco to Los Angeles and beyond;** in fact, well past Long Beach.

That line of bumper-to-bumper ambulances would be 477 miles long!

The Picture by Industries

If the long line of ambulances were divided into sections according to the industry groups in the California Industrial Safety Conference, we would find this:

From San Francisco to Turlock, the ambulances would carry **manufacturing** workers.

From Turlock to Fresno, the ambulances would carry **construction** workers.

From Fresno to Tulare, the ambulances would carry farm workers.

From Tulare to Delano, the ambulances would carry **government** workers (state and local).

From Delano to Bakersfield, the ambulances would carry **forest products** workers.

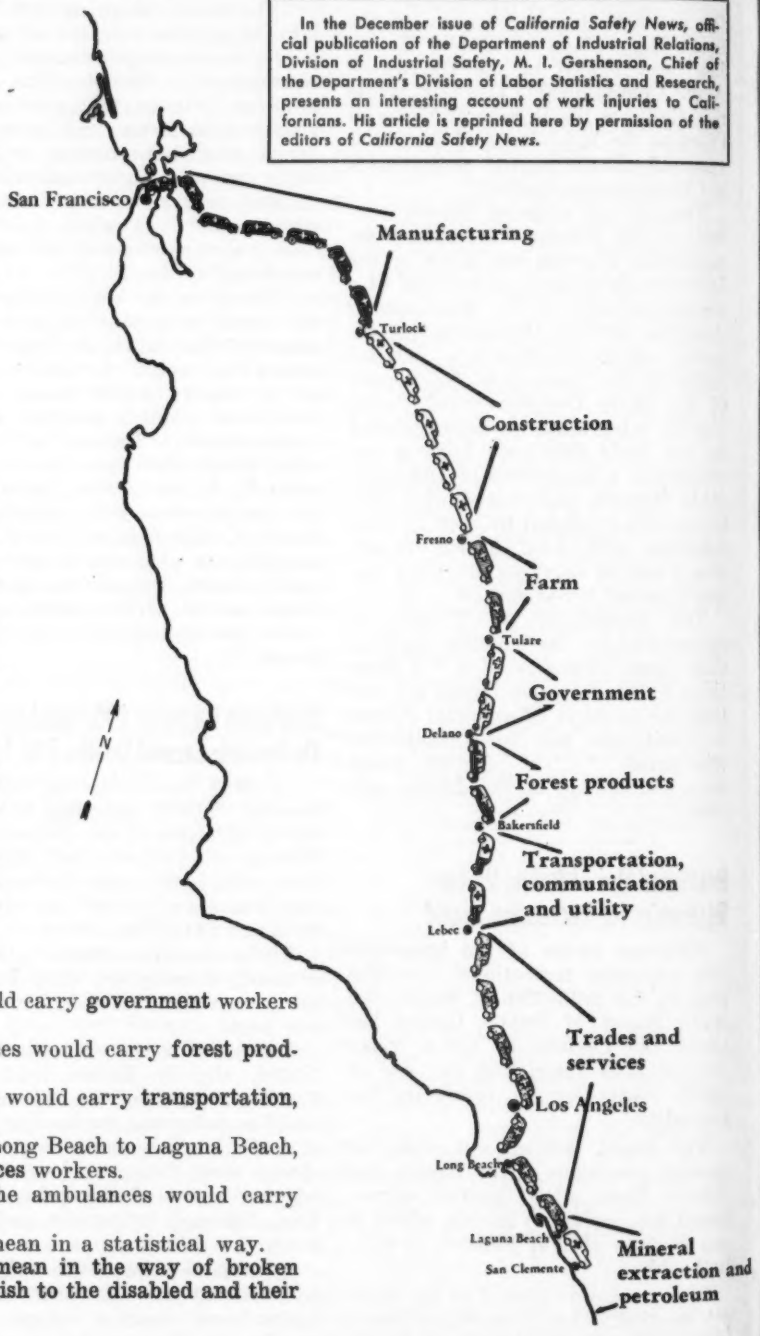
From Bakersfield to Lebec, the ambulances would carry **transportation, communication, and utility** workers.

From Lebec through Los Angeles through Long Beach to Laguna Beach, the ambulances would carry **trades and services** workers.

From Laguna Beach to San Clemente, the ambulances would carry **mineral extraction and petroleum** workers.

We have shown briefly what the figures mean in a statistical way.

There is no way of showing what they mean in the way of broken homes, hardships, suffering, sorrow and anguish to the disabled and their loved ones.



Developments in Occupational Health Noted in San Diego and Vernon

For the past several years California's rapid industrial growth has been reflected in the increasing number of requests coming to the Department's Bureau of Adult Health from industrial areas for assistance on occupational health problems. The need for local staff in this phase of public health effort has been pointed up in a number of localities. Recently a full-time industrial hygiene engineer was employed by the San Diego Health Department and a sanitation director was employed by the City of Vernon in Los Angeles County. These developments in occupational health are the culmination of a long period of activity devoted to bringing about increased attention to occupational health in those areas.

In 1949 an industrial health survey including 415 plant visits was conducted in San Diego County by the Bureau of Adult Health. Survey recommendations included the need for a full-time industrial hygienist. Since that time continued expansion of industry and repeated requests for assistance on occupational health problems have pointed up the need for an industrial hygiene program in San Diego.

Expansion of the public health program in Vernon to meet the industrial health needs of the wide variety of manufacturing establishments of various sizes in that city has also been indicated for a number of years.

The Bureau of Adult Health will continue to provide consultation, training, and other services when requested by these two health departments to aid their new personnel in the initial phases of development of their programs.

Very few people die today of old age. People die of chronic degenerative diseases. Once we are able to control the development of chronic ailments and their cause, we may expect that we can really live to the natural limit of our life span * * *, which will, as many scientists believe, be somewhere between 110 and 125 years.—*Martin Gumpert, M.D., in the University of Chicago Roundtable on "Problems of Aging."*

Department Co-sponsors Institute for Nurses Engaged in School Health Work

The Bureau of Public Health Nursing of the State Department of Public Health and the State Department of Education co-sponsored a two and one-half day institute in December for nurses engaged in school health work in Northern California. This was the tenth such institute conducted by the State Department of Public Health and the second jointly sponsored with the State Department of Education.

These institutes are planned primarily to assist nurses who have limited opportunities to participate in local in-service educational programs. Participants in the program included representatives from the two sponsoring departments, the State Department of Mental Hygiene, the University of California, the State Tuberculosis and Health Association, a health officer and school physician, as well as school administrators, supervisors and nurses. Topics considered were: working with private physicians in school health programs; health councils; interrelationships between school health services and physical education programs; helping to solve the problems of children and accident prevention. Total registration at the institute was 221, representing 33 counties.

Because of the growing recognition of the fact that the school health program involves many different kinds of personnel, it appears that in planning for future meetings, consideration should be given to bringing together others concerned with the school health program rather than nurses alone. Recommendations coming out of the meeting of the California Medical Association Conference of Physicians in School Health will be taken into consideration in future planning.

The primary responsibility for health protection rests upon an alert and informed public.—*National Health Council.*

The National Safety Council estimates that some fifteen and a half million drivers are involved in accidents annually.

Department Veterinarian to Assist Peru, Ecuador, in Setting Up Animal Care Program

Orland A. Soave, D.V.M., Assistant Public Health Veterinarian, Division of Laboratories, has been loaned to the Pan American Sanitary Bureau for three months to assist the South American Countries of Peru and Ecuador in establishing laboratory animal care programs. Dr. Soave has had the administrative responsibility for carrying out the department's laboratory animal care program in California for the past year.

Laws and regulations relating to the care and use of laboratory animals in California are the basis for one of the few programs of this kind in the Nation. These laws, adopted by the 1951 Legislature and followed by implementing regulations adopted by the State Board of Public Health, are administered by the Laboratory Field Services of the Division of Laboratories. It is gratifying that our programs are of sufficient importance to warrant their adaptation by other nations.

Trudeau Sanatorium Closes

Trudeau Sanatorium, the Nation's oldest private sanatorium for the treatment of tuberculosis, located at Saranac Lake, New York, closed its facilities last month. It was founded in 1884 as the Adirondack Cottage Sanatorium by Dr. Edward Livingston Trudeau, one of the great pioneers in the tuberculosis control movement in the United States. Dr. Trudeau helped to organize the National Tuberculosis Association and became its first president in 1904.

Closing of the Trudeau Sanatorium is regarded by tuberculosis experts as symbolizing the beginning of the final assault against a deadly enemy, but they caution that victory is not yet won. They now feel that treatment programs should be further concentrated in the larger hospital centers, where extensive surgical and laboratory facilities are justifiable and the latest methods of drug and antibiotic therapy are readily available under controlled conditions.

In the era of the Trudeau Sanatorium the fight against tuberculosis has been a dramatic one At the turn of the century available statistics showed California's tuberculosis death rate to be in excess of 250 per 100,000 population. Last year this rate was 11.4 deaths per 100,000.

In recent years state and local governments have stepped up their programs of early detection, hospital care, and rehabilitation of the tuberculous. At the same time tuberculosis associations have intensified their educational campaigns and their community demonstrations of tuberculosis control. Private physicians have extended their case-finding efforts among office patients and family contacts. Tuberculosis experts stress that despite this combined cooperative effort, the need is still urgent for renewed vigor in the campaign to stamp out the disease and now is the time to intensify efforts to keep tuberculosis on the decline and hasten the day of its inevitable control.

Review of Reported Communicable Diseases Morbidity by Month of Report—December, 1954

Diseases With Incidence Exceeding the Five-year Median

Diseases	*Dec. 1954*	*Dec. 1953*	*Dec. 1952*	*Five-year Median*
Amebiasis	46	42	63	42
Chickenpox	3,042	2,777	2,014	2,208
Diphtheria	10	6	4	6
Food poisoning	78	9	5	45
German Measles	364	280	355	214
Hepatitis, infectious	216	180	108	49
Malaria	4	8	7	2
Measles	1,465	1,620	1,085	1,060
Meningitis, meningococcic	29	40	37	22
Mumps	2,541	2,674	3,089	2,051
Pertussis	583	177	330	269
Salmonella infections	138	104	111	97
Shigella infections	113	105	114	74
Streptococcal infections, Resp. incl. Scarlet Fever	757	813	688	688

Diseases Below the Five-year Median

Diseases	*Dec. 1954*	*Dec. 1953*	*Dec. 1952*	*Five-year Median*
Brucellosis	6	3	9	9
Coccidioidomycosis (disseminated)	5	4	14	6
Encephalitis, infectious, W.E.	---	---	7	2
Encephalitis, infectious, St. Louis	---	---	2	2
Encephalitis, infectious (undetermined)	10	15	12	12
Influenza	5	40	125	31
Poliomyelitis (total)	165	323	438	226
Poliomyelitis (paralytic)	100	214	263	161
Rabies, animal	4	25	10	10
Tetanus	4	5	8	5
Typhoid Fever	6	11	9	9

Venereal Diseases

Diseases	*Dec. 1954*	*Dec. 1953*	*Dec. 1952*	*Five-year Median*
Syphilis	574	520	496	555
Gonococcal infections	1,423	1,429	1,373	1,373
Chancroid	8	13	9	[1]
Granuloma inguinale	---	1	3	[1]
Lymphogranuloma venereum	8	8	4	[1]

[1] Median not calculated.

printed in CALIFORNIA STATE PRINTING OFFICE

Entered as second-class matter Jan. 25, 1949, at the Post Office at San Francisco, California, under the Act of Aug. 24, 1912. Acceptance for mailing at the special rate approved for in Section 1103, Act of Oct. 3, 1917.

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